CENTERS FOR MEDICARE & MEDICAID SERVICES

10/14/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL | LE CONSTRUCTION | COMPI | | |
|---|---|---|--|---|-------------------|--------------------|
| AND FLAN | OF CORRECTION | 15G616 | A. BUILDING | 00 | 09/15/2 | |
| | | 130010 | B. WING STREET ADDRESS_CITY_STATE_ZIR_CODE | | | 2011 |
| NAME OF PROVIDER OR SUPPLIER WABASH CENTER INC | | 396 | EET ADDRESS, CITY, STATE, ZIP CODE 64 ABRAHAM COURT FAYETTE, IN47905 | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL PECULIATORY OR LSC INCINITIEVING INFORMATION) | | ID PREFIX | PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOULD CORRECTED TO THE ADDRESS | D BE | (X5) COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRODEFICIENCY) | PRIATE | DATE |
| W0000 | | | | | | |
| | This visit was for complaint #IN00 | | W0000 | | | |
| | the post-certificat | ne in conjunction with tion revisit (PCR) to the omplaint #IN00091974 ne 29, 2011. | | | | |
| | federal/state defic | 2095204: Substantiated, ciencies related to the ed at W149 and W227. | | | | |
| | Dates of Survey: 2011 | September 14 and 15, | | | | |
| | Facility Number: Provider Number AIMS Number: | | | | | |
| | Surveyor: Claud Nurse Surveyor I | ia Ramirez, RN, Public II/QMRP | | | | |
| W0149 | findings in according Quality Review come Program Coordinate The facility must distribute policies and | es also reflects state dance with 431 IAC 1.1. pleted 9-29-11 by C. Neary, r. evelop and implement d procedures that prohibit ect or abuse of the client. | | | | |
| | facility neglected neglect policy an | to implement their d neglected to protect 1 A) from injury which | W0149 | All staff will be re-trained QMRP on Wabash Cent Policy of Abuse/Neglect/Exploitati A's BSP will be revised t | er's on.Client | 10/15/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUC | | NSTRUCTION | (X3) DATE SURVEY | |
|---|--|------------------------------|------------------------|---------------------|--|------------------|--------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | , DIII | DING | 00 | COMPL | ETED |
| | | 15G616 | | A. BUILDING B. WING | | | 011 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | BRAHAM COURT | | |
| WABASH CENTER INC | | | 1 | ETTE, IN47905 | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | | | | | |
| | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | | | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION DATE |
| IAG | | LSC IDENTIFYING INFORMATION) | + | IAG | additional protective measure | 20 | DATE |
| | resulted a fractul | red hand from a fall. | | | regarding Client A's self-injur | | |
| | | | | | behaviors. All staff will be tra | | |
| | Findings include: | | | | on the changes made to Clie | | |
| | | | | | A's BSP by the QMRP.All cli | | |
| | On 09/14/11 at 2 | 2:36 PM, a record review | | | BSPs will be reviewed by the | : IDT | |
| | of the facility's r | eports to BDDS (Bureau | | | to ensure that they are | | |
| | of Developmenta | al Disabilities Services) | | | comprehensive and do adequately address each | | |
| | was completed a | nd included the following | | | client's behavioral needs. If a | _{iny} | |
| | incident: | _ | | | BSPs are discovered to be | ´ | |
| | | | | | inadequate, revisions will be | | |
| | A BDDS report dated 08/12/11 for an | | | | made. Both the QMRP and t | | |
| | incident on 08/1 | | | | Behavior Specialist will revie clients' monthly behavioral d | | |
| | | A, indicated, "Staff | | | (BPRs) to determine whethe | | |
| | - | MRP (Qualified Mental | | | there are any new behaviora | | |
| | 1 * | | | | trends presented by a client. | | |
| | | Sessional) that [client A] | | | trends are discovered, revision | | |
| | 1 | the pinky finger of her | | | will be made to the client's B | SP to | |
| | | hat appears to be the | | | address the new issue. | | |
| | | k on her head, along the | | | | | |
| | | ea on her head did not | | | | | |
| | | attention. The QMRP | | | | | |
| | _ | gation. The QMRP | | | | | |
| | suspended staff i | member [staff #1] | | | | | |
| | pending an inves | stigation. [Client A] is | | | | | |
| | being sent for an | x-ray of her right hand." | | | | | |
| | | | | | | | |
| | A BDDS follow- | -up report dated 08/17/11 | | | | | |
| | | nvestigation has been | | | | | |
| | completed and the results are inconclusive | | | | | | |
| | _ | ient A] was abused or | | | | | |
| | _ | ries were a result of | | | | | |
| | 1 | havior. An x-ray of | | | | | |
| | | hand revealed a fracture." | | | | | |
| | [chem A's] right | nand revealed a fracture. | | | | | |
| | 1 DDD 2 2 11 | 1 1 1 20/21/11 | | | | | |
| | A BDDS follow | -up report dated 08/24/11 | | | | | |

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE S COMPL | ETED |
|-----------|--|---|----------|---------------------|--|----------------------|------------|
| | | 15G616 | B. WIN | | | 09/15/2 | 011 |
| NAME OF 1 | PROVIDER OR SUPPLIEF | 2 | | 1 | DDRESS, CITY, STATE, ZIP CODE | | |
| WABASI | H CENTER INC | | | | BRAHAM COURT ETTE, IN47905 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤΕ | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | <u> </u> | TAG | DEFICIENCY) | | DATE |
| | indicated, "The | e investigation | | | | | |
| | determined that | abuse could not be | | | | | |
| | substantiated bed | cause [client A] had a | | | | | |
| | behavior the day | before the injuries were | | | | | |
| | discovered in wh | nich she threw herself to | | | | | |
| | the ground and b | egan flailing her arms | | | | | |
| | and legs at a den | tist appointment. It is | | | | | |
| | possible the inju | ry to her hand was | | | | | |
| | sustained at that | time." | | | | | |
| | | | | | | | |
| | Client A's record | ls were reviewed on | | | | | |
| | 09/15/11 at 11:0 | 0 AM. Client A's Record | | | | | |
| | contained the fol | llowing dated documents: | | | | | |
| | | | | | | | |
| | 04/13/11: Emer | gency room visit, "to | | | | | |
| | · · | self injurious behavior. | | | | | |
| | | - right fracture." | | | | | |
| | | | | | | | |
| | 04/21/11: Visit t | to psychiatrist indicated | | | | | |
| | client A had incr | eased agitation and a | | | | | |
| | | ease was ordered. | | | | | |
| | | | | | | | |
| | 05/05/11: Visit t | to psychiatrist indicated | | | | | |
| | | eased agitation and a | | | | | |
| | | ease was ordered. | | | | | |
| | | | | | | | |
| | 05/19/11: Visit t | to psychiatrist indicated | | | | | |
| | | eased agitation and a | | | | | |
| | | ease was ordered. | | | | | |
| | | | | | | | |
| | 06/2, 6, 7, 8, 11, | 14, 15, 16, 17, 21, 22, 23, | | | | | |
| | | vioral tracking record | | | | | |
| | | ed behaviors which | | | | | |
| | | and, screaming, grabbing | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G616 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPI 09/15/2 | LETED | |
|---|--|---|--------|---------------------|--|-------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WABASH CENTER INC | | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE BRAHAM COURT ETTE, IN47905 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | (X5) COMPLETION DATE |
| | indicated, "Area physical assaults to peers and staff due to [client A's wear a helmet at showering or who or 11, 12, 13, 18 Behavioral track recorded behavioral staff. 08/2, 3, 4, 5, 7, 8 and 29: Behavioral included biting hand hitting staff. The facility's reconstitute of 12 to 12 to 13 to 14 to 15 to 1 | ing record indicated ors which included biting grabbing and hitting and hitting and hitting and hitting and racking record ed behaviors which and, screaming, grabbing ords were reviewed on PM. A review of the and Procedures for | | | | | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|---------------------------|--|--|------------------------|--|---------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A DAW DDIG | 00 | COMPLETED | |
| | | 15G616 | A. BUILDING B. WING | | 09/15/2011 | |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | t . | | BRAHAM COURT | | |
| WABASH CENTER INC | | | ETTE, IN47905 | | | |
| | | | | 1 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| PREFIX TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE COMPLETION DATE | |
| IAG | | | iAd | 1 | DAIL | |
| | _ | ency had previous | | | | |
| | _ | ent A's behaviors which | | | | |
| | | nduced fractured nose on | | | | |
| | 04/13/11. He inc | dicated staff neglected to | | | | |
| | protect client du | ring her behavioral | | | | |
| | episode on 08/11 | /11 during the dentist | | | | |
| | visit, when she tl | nrew herself to the | | | | |
| | cement in the parking garage which was | | | | | |
| | the probable cau | se of her fractured hand. | | | | |
| | 1 | | | | | |
| | This federal tag relates to complaint | | | | | |
| | #IN00095204. | | | | | |
| | <i>"</i> 11100032201. | | | | | |
| | 1.1-3-2(a) | | | | | |
| W0227 | The individual program plan states the | | | | | |
| W 0227 | | specific objectives necessary to meet the | | | | |
| | client's needs, as | | | | | |
| | comprehensive assessment required by | | | | | |
| | paragraph (c)(3) of this section. | | ****** | Oli and Ala DOD will be may in | 40/47/2044 | |
| | | review and interview for | W0227 | Client A's BSP will be revise include additional protective | 10/13/2011 | |
| | • | ents (client A) with a | | measures regarding Client A | | |
| | • | e facility failed to | | self-injurious behaviors. All staff will be trained on the changes | | |
| | address client A's | s self-injurious behavior. | | | | |
| | | | | made to Client A's BSP by the | • | |
| | Findings include | : | | QMRP.All clients' BSPs will reviewed by the IDT to ensu | | |
| | | | | that they are comprehensive | | |
| | On 09/14/11 at 2 | :36 PM, a record review | | do adequately address each | | |
| | of the facility's re | eports to BDDS (Bureau | | client's behavioral needs. Bo | oth | |
| | | al Disabilities Services) | | the QMRP and the Behavior | | |
| | • | nd included the following | | Specialist will review clients' | | |
| | incident: | - · · · · · · · · · · · · · · · · · · · | | monthly behavioral data (BF to determine whether there | · • | |
| | | | | any new behavioral trends | | |
| | A RDDS report (| dated 08/12/11 for an | | presented by a client. If tren | ds | |
| | incident on 08/11 | | | are discovered, revisions wi | ll be | |
| | | · · · · · · · · · · · · · · · · · · · | | made to the client's BSP to | | |
| | l regarding client A | A, indicated, "Staff | | | | |

001205

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G616 | (X2) MULTIPLE A. BUILDING B. WING | 00 | li i | E SURVEY PLETED 2011 | | |
|--|--|--|---|--|-----------|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER WABASH CENTER INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3964 ABRAHAM COURT LAFAYETTE, IN47905 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| | reported to the C Retardation Profi had bruising on right hand and w marking of a for hairline. The are require medical began an investi suspended staff pending an invest being sent for an A BDDS follow- indicated, "The completed and th as to whether [c] whether the inju self-injurious be [client A's] right A BDDS follow- indicated, "Th determined that substantiated be- behavior the day discovered in wh the ground and be and legs at a den possible the inju sustained at that Client A's record 09/15/11 at 11:0 | OMRP (Qualified Mental Sessional) that [client A] the pinky finger of her what appears to be the k on her head, along the ea on her head did not attention. The QMRP gation. The QMRP gation. The QMRP member [staff #1] stigation. [Client A] is a x-ray of her right hand." up report dated 08/17/11 investigation has been the results are inconclusive tient A] was abused or ries were a result of havior. An x-ray of hand revealed a fracture." up report dated 08/24/11 to investigation abuse could not be cause [client A] had a to before the injuries were nich she threw herself to began flailing her arms attist appointment. It is rry to her hand was | | address the new iss | sue. | DAIL | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G616 | | | (X2) M A. BUI B. WIN | LDING | nstruction 00 | (X3) DATE : COMPL 09/15/2 | ETED |
|---|---|--|----------------------------|---------------------|--|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WABASH CENTER INC | | | p. w.i. | STREET A | DDRESS, CITY, STATE, ZIP CODE BRAHAM COURT ETTE, IN47905 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | check nose after | gency room visit, "to self injurious behavior. 7 - right fracture." | | | | | |
| | 04/21/11: Visit to psychiatrist indicated client A had increased agitation and a medication increase was ordered. | | | | | | |
| | 05/05/11: Visit to psychiatrist indicated client A had increased agitation and a medication increase was ordered. | | | | | | |
| | 05/19/11: Visit to psychiatrist indicated client A had increased agitation and a medication increase was ordered. | | | | | | |
| | 24 and 30: Beha indicated records | 14, 15, 16, 17, 21, 22, 23, avioral tracking record ed behaviors which hand, screaming, grabbing | | | | | |
| | indicated her bel picking at her sk lesion. The BSP | Behavior Support Plan) navior included only in/or nails resulting in a did not contain any g her hand or throwing or/ground. | | | | | |
| | recorded behavio | ing record indicated ors which included biting grabbing and hitting | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|---|------------------------------|--------------------|----------------|--|----|--------------------|
| 15G616 | | A. BUII | | | 09/15/2 | | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | 3964 ABRAHAM COURT | | | | |
| WABASH CENTER INC | | | | LAFAYE | ETTE, IN47905 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION DATE |
| IAG | staff. | LSC IDENTIFYING INFORMATION) | | IAG | DLI ICILICI I | | DATE |
| | Staff. | | | | | | |
| | 08/2, 3, 4, 5, 7, 8 and 29: Behavior indicated recorder included biting hand hitting staff. An interview was 09/15/11 at 1:35 indicated the age knowledge of clicincluded a self in 04/13/11. He included a self in herself to the centagrage at the den probable cause of QMRP indicated contain the behavior throwing herself. | _ | | | | | |
| | | | | | | | |